Medway Safeguarding Children Board

Safeguarding Medway's children together

# Medway

# Safeguarding Children Board

## Serious Case Review

## "Faith"


**Report Author**

**Jane Wonnacott**

MSc MPhil CQSW AASW

Director, Jane Wonnacott Safeguarding Consultancy Ltd


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## 1 INTRODUCTION

1.1 This report is about "Faith"[1] who, as a child and young person, had contact with several organisations in Medway. This serious case review was commissioned following a retrospective review of Faith's health records in December 2016. The health review identified that as a child Faith had been seen by health practitioners with symptoms that may have been indicative of sexual abuse and that there appeared to have been a failure of multi-agency responses to indicators of risk throughout her childhood.

1.2 The apparent failure to protect had first been identified by the nurse for looked after children in January 2016, just prior to Faith's eighteenth birthday and Faith had confirmed to the nurse that she had been sexually abused by a neighbour for a number of years and her mother had been aware that this was happening. The nurse made Children's Social Care aware of this disclosure. Although there has been no prosecution of any offender, there are many occasions when the possibility that Faith was being sexual abused should have been acted upon.

1.3 A referral was made to Medway Local Safeguarding Children Board in March 2017 for the case to be considered for a multi-agency review or audit as Faith's experiences have had a serious adverse impact on her emotional and mental health and it was believed that there were lessons that could be learned about the way that agencies work with suspected sexual abuse.

1.4 Following further discussions, in August 2017 the decision was made that the case met the criteria for a serious case review[2] as a child had been seriously harmed and there was cause for concern as to the way in which the authority, their Board partners or other relevant persons had worked together to safeguard the child.

1.5 It has been the aim of the panel to include Faith in the process as much as she wished to do so, and this review has been driven by Faith's wish to understand what happened to her and why she was not protected. We hope that this review will, to some extent, help her with this wish and in order to provide enough information for Faith it has been necessary to provide a certain level of detail that might not be usual in a published report. It has also meant that events some years ago have been explored in more detail than might be the case in other reviews. The review team have been very grateful to Faith for contributing to the review and for her insight into events throughout her life. This has provided important information which has greatly influenced the conclusions of this review.

1.6 This review has not been completed within expected timescales. This is primarily due to challenges in gathering non-recent information as well as trying to ensure maximum collaboration with Faith and the practitioners involved.

[1] Faith is a pseudonym agreed with the subject of this review.
[2] As set out in Working Together to Safeguard Children (2015) Page 75

## 2 THE REVIEW PROCESS

2.1 An independent lead reviewer was commissioned in October 2017 to work with a panel of senior professionals within Medway in order to carry out the review. The panel was chaired by a senior police officer. Further details of the lead reviewer and panel members are set out in Appendix 1.

2.2 At the start of the review, all organisations who had worked with Faith were asked to provide a summary chronology of their involvement from the time of Faith's birth through to 2016 when the referral was made to Children's Social Care regarding Faith's experience of sexual abuse. Individual chronologies were received from:

- Medway Council Youth Offending Team
- Medway Council Children's Services
- Medway Council IRO Service
- Medway NHS Foundation Trust
- Child and Adolescent Mental Health Services (CAMHS) - Sussex Partnership
- Medway Community Healthcare
- GP's
- Kent Police
- Secondary School 1
- Secondary School 2
- Primary Schools x 3
- Independent Special school
- Residential Placement 1
- Residential Placement 3
- Residential Placement 6
- Medway Foster Carer Placement

2.3 The panel considered these chronologies and identified questions that should be considered by the serious case review. These questions are set out in appendix two of this report. The panel also identified further written information that would assist the review and all documents considered by the lead reviewer are set out in appendix three.

2.4 Practitioners who had known Faith were invited to speak to the lead reviewer in order to assist the review in understanding what had influenced practice decisions at the time. It has not been possible to speak to all who knew Faith as, due to the passage of time not all could be traced or were available. However, sufficient numbers have been available to provide the review with a degree of assurance that the panel's understanding of the factors influencing practice is credible. The information provided by Faith herself has also been invaluable in helping the review to reach its findings and recommendations.

2.5 Following a review of all the information the lead reviewer agreed a draft of the report with the panel which was then shared with all those who had contributed to the

review including Faith. Faith told the review that she wished for the full report to be published in order to make sure that everyone understood what could have been done differently and how services need to improve.

2.6 The report was agreed by Medway Safeguarding Children Board in May 2019.

**Constraints**

2.7 Understanding what happened and why it happened when Faith was a very small child has been hampered by gaps in records and the fact that many staff are no longer working for the organisation concerned. Primary school records for two of the schools attended by Faith contain very little information from that period and the independent special school records are minimal. Records within the Hospital Trust are available but have not helped to explain issues raised by this review and whilst Children's Social Care records are reasonably comprehensive, they do not identify clearly the rationale for all of the decisions made.

2.8 The review has identified a specific problem with obtaining non-recent GP paper records and has not been successful in doing so despite the best efforts of Medway Clinical Commissioning Group. These records are managed on behalf of NHS England by a private company and the review has been informed that this company are unable to process the application because the patient is registered with a GP and this can only be done through the GP practice. The GP practice have also not been able to obtain the records and the review has heard that the system for obtaining non-recent records is one that frustrates many GPs in their day to day practice. A recommendation regarding this issue is therefore included at the end of this report.

2.9 The final review question requested by the panel was for this report to identify what is happening now across the partnership to improve practice in similar situations and are there further improvements that need to be made? It is not the purpose of a serious case review to audit current practice, but the panel felt that due to the non-recent nature of much of the information in this review, comment should be made on where practices have changed. Comment is made within the findings, but this should not be taken as a comprehensive review of current practice; any such review will need to be carried out by the local partnership, taking account of the findings of this review.

## 3 SUMMARY OF FINDINGS

3.1 The overall conclusion of this review is that Faith was let down by a safeguarding system that failed to recognise signs and indicators of abuse and to take action to protect her as a small child. This system is made up of organisations and individuals who work within local and national policies and guidance. Although there are examples of poor individual practice this took place within an overall context of organisational systems which did not provide the checks and balances that are needed to ensure that children are kept safe from harm. Managerial oversight and

supervision of individual practice did not provide sufficient scrutiny and challenge, particularly within social care, and organisational systems did not identify where processes failed, for example the delay in responding to a GP referral to the paediatrician.

3.2 There was information available to agencies and individual practitioners when Faith was a small child that should have been explored more systematically and the possibility that Faith was being sexually abused considered more thoroughly. Actions taken were not in line with procedures or professional knowledge at that time. Although professional knowledge and confidence in recognising and working with child sexual abuse should now have increased, a relatively recent study by the Children's Commissioner found that there are still challenges in working with child sexual abuse within a family environment,[3] and called for the practice of professionals in identifying children who are being sexually abused to be strengthened. The Commissioner's finding is relevant in this case.

3.3 Practitioners need to understand the barriers that might prevent children from talking openly about their experiences and find creative ways to engage with them. Children's behaviour needs to be understood as a form of communication and in this case the potential that Faith's change in demeanour as a small child might be indicative of sexual abuse could have been explored more fully. The human response to Faith as a troubled child was not apparent and her behaviours meant that she became the problem to be managed, rather than there being a sufficient level of understanding of the factors that might be causing her behaviour. This could have included a greater focus on the family dynamics and the needs of individual adults and children within the family.

3.4 As a result, the system continued to fail Faith as she grew up and her behaviours became defined as problematic and challenging, rather than being understood as a response to her experiences within her family. As a result, practitioners paid insufficient attention to the complexity of her family relationships and how these continued to affect her even though she was living away from home. Contact arrangements with her family were not clearly specified and monitored and there was no clear plan as to how to best work with Faith and members of her family to achieve a permanent solution.

3.5 Underpinning this is the need for practitioners to be able to work with layers of complexity and need within families. A recent study[4] noted that parents involved in care proceedings experienced entrenched and serious violence, drug and alcohol addiction or sexual abuse, often over many years and mostly in the context of poverty and deprivation. Faith's situation was no different. In such circumstances, practitioners need to be able to move beyond simple solutions and one key message

[3] Children's Commissioner (2015) *Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action* https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/06/Protecting-children-from-harm-executive-summary_0.pdf

[4] Trowler, I (2018) *Care Proceedings in England: The Case for Clear Blue Water.* University of Sheffield and Crook Public Service Fellowships.

is the need for professionals to be able to work confidently with families where there are multiple issues.

3.6 Many changes have taken place in work with children and families since the events set out in this review. Most notably, care planning for looked after children in Medway is more structured and there would for example be a formal assessment of any family member who wished to care for a child. Police practices have changed with more emphasis on listening to children and there is a sexual abuse pathway in place to assist practitioners when this is a concern. There is however no room for complacency and much more that can be done to make a positive difference to the lives of children who may be in a similar situation to Faith. The findings and recommendations of this report set out where further work needs to be done by those agencies with responsibility for protecting children.

## 4 FAMILY BACKGROUND

4.1 Faith's mother had two children from a previous relationship (known in this report as Half Sibling 1 and Half Sibling 2). Faith is the oldest child of her mother and father's relationship and has two younger siblings.

4.2 There is little on record regarding Father and Mother's history. Faith told the review that her mother's first partner was in the armed forces and she lived with him overseas where her oldest children were born. On returning to the UK she started a relationship with Faith's father.

4.3 Investigations for this review have found that Father had 17 convictions for 41 offences between 1970-2007, several suspended sentences and six terms of imprisonment. The most recent term of imprisonment was in 1999 when he received a two-year sentence for drug offences. From Faith's perspective this is important information that should have been taken into account and, although the information is mentioned from time to time in the records, it was not always explored in assessments relating to the children in the family.

## 5 FAITH'S CARE HISTORY

5.1 Faith was accommodated under Section 20[5] for two periods of time and moved through several placements. These were as follows:

| Placement | Dates | Type of Placement | Education |
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[5] Section 20 Children Act 1989 requires the Local Authority to provide accommodation for a child where: *(a) No person has parental responsibly for them. (b)They have been lost or been abandoned. (c) The person who has been caring for the child is prevented permanently or not, from providing him or her with suitable accommodation or care.*

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|---|---|---|---|
| Foster Carers 1 | May 2010 – Sept 2010 | | |
| Foster Carers 2 | Sept 2010 – June 2011 | | Secondary School |
| *Period in Care ended, and Faith lived with her sister and then her father* | | | Secondary School |
| Residential Placement 1 | November 2012- Feb 2014 | A local Authority placement in Medway | Secondary School<br><br>Independent Special School (July 2013 – Feb 2014) |
| Residential Placement 2 | Feb 2014 – May 2014 | Out of Borough Therapeutic placement | Out of county school |
| Residential Placement 3 | Aug 2014 – Jan 2015 | Local 16+ accommodation | Left education |
| Residential Placement 4 | Jan 2015 | Out of Borough residential home | |
| Residential Placement 5 | October 2015 | Local semi-independent accommodation | |
| Residential Placement 6 | December 2015 | Supported independent accommodation | |

## 6 SUMMARY OF AGENCY INVOLVEMENT

6.1 When Faith was a small child the agencies with most involvement with her family were police and health practitioners.

6.2 Police involvement was primarily as a result of neighbourhood disputes, allegations of domestic violence involving Faith's parents and drug related offences. In April 2004 (when Faith was six) there was an allegation of sexual assault committed by Faith's father towards his fifteen-year-old niece. Children in the family were spoken to by a police officer and a social worker and said all was well. There was no further action due to lack of evidence as the victim did not want to proceed. This episode should now be understood in the light of Faith's submission to the review which speaks of the difficulties for a young child in talking to professionals when told by their family not to say anything.

6.3 The Children's Social Care assessment noted that Faith had been taken to the GP on several occasions and that a GP (a locum) had made an urgent referral to the Community Paediatric Department highlighting physical symptoms that could be

indicative of sexual abuse. It also contained information about Faith's sexually explicit behaviour at school which was beyond that expected of a six-year-old. However, the final analysis failed to take this into account in reaching the conclusion that there was no evidence that Faith could have been harmed.

6.4 In the referral to the hospital, the GP had highlighted social problems including Mother's alcohol abuse and asked for advice on "*this very delicate situation as she may be at risk".* This referral was sent to the community paediatricians rather than directly to the hospital paediatricians, but this does not explain why the hospital did not pick up the referral until nineteen months later. This was not acceptable, and the Hospital Trust has been unable to provide the review with a full explanation as to why this delay occurred. The specific sequence of events at that point is set out in Paragraphs 9.8 and 9.9 of this report.

The locum GP was proactive in recognising possible risks within the family, but this became lost due to

- the referral being framed as a request for advice from a medical colleague rather than a child protection referral to Children's Social Care and a request for a medical under child protection procedures
- lack of involvement by specialist medical practitioners such as the Named or Designated doctors who could have given advice to the GP
- lack of a timely response from the paediatric department at the hospital

The concerns of the GP and the school were not understood by Children's Social Care in relation to the allegation of sexual assault made against Faith's father and other information known to the police about the family within the community.

6.5 By the age of nine, Faith's primary school identified that she had gone from a bright and happy child to one who was "weak and unable to concentrate". The school made a referral to Children's Social Care which also highlighted continuing disputes with neighbours and that Faith had reported being tied up by a neighbour and that her mother had been stabbed. An initial assessment by Children's Social Care resulted in no further action; the reason being that the neighbour had moved out and the home situation had calmed down. There was insufficient consideration given as to why Faith's family had failed to protect her.

6.6 There was a further referral from the police two months later following an allegation that Father had assaulted Mother. This resulted in a child protection conference and Faith and Sibling 1 and 2 were placed on the child protection register under the categories of physical and emotional abuse. The plan from this conference was a series of tasks with little evidence of how these would improve the safety and wellbeing of children in the family.

6.7 At a review child protection conference three months later, the situation was described as much improved although there was no report from the school to give information about the family from their perspective. It was acknowledged that three

months was a short time to be sure changes could be sustained and a further conference was convened a month later when it was agreed that Faith would receive counselling at school and the child protection plan should be discontinued. The family transferred to the local family and social support team for on-going monitoring and support.

6.8 Following this, there was an allegation of domestic abuse and numerous allegations and counter allegations between the family and the neighbours with police records noting that two families between them were responsible for reporting around 50 crimes against each other. The case was closed to Children's Social Care and child in need meetings continued at Faith's school.

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| By this stage it was clear that this was a complex family with multiple needs, and it is unlikely that monitoring and low-level support would facilitate enough change. An outcome focused plan which took account of the needs of adults and children within the family and had clear measures for success would have been more likely to succeed in improving the life chances of Faith. |

6.9 Faith started secondary school in September 2009 and in November 2009, when she was eleven, there was a "child protection referral" from housing as Mother had left the family home taking Faith with her. This referral is significant as it quotes information that the social worker had given to housing that "father is a great influence on the children". Inaccurate information was also quoted as the referral noted that the previous referral was due to Mother's drinking rather than domestic abuse. At this point it appears that Father was seen as a resource and any information to the contrary was not considered. An Initial assessment started.

6.10 At this time Faith was apparently moving between her Mother and Father's address; torn between her parents and noted to be extremely distressed. Faith's school alerted the social worker and on a visit to the home Father was noted to be aggressive to Faith. Arrangements were made for Faith to stay with her half-sister (Half Sibling 1) who by now had a baby and had moved out of the family home.

6.11 In December 2009, a child protection conference took place and Faith and her two siblings were made subject of a plan. The main issues highlighted within the social work report were Mother's alcohol use and Father's violence and cannabis use.

6.12 Meanwhile, Father had applied for a Residence Order and an Interim Order was made in respect of all three children which stipulated that Faith was to remain with Half Sibling 1. At the final court hearing the social worker supplied a Section 7 report[6] to the court which did not support Father's application for a Residence Order for either Faith or her siblings. The social worker preparing the report had referred to concerns about Father's capacity to parent, but the court decided to grant a Residence Order for the two younger siblings although not for Faith who remained

[6] A Section 7 assessment and associated report derives its name from Section 7 Children Act 1989 which empowers the court to ask a Cafcass Officer to report to the court on matters relating to the welfare of the child in order to help the judge make a safe decision.

with her half-sister. Soon after this the social worker responsible for Faith changed and it seems that some of the misgivings about Father were not seen in the same light from that point forwards.

6.13 In May 2010 concerns about Faith increased and she was accommodated by the Local Authority (with her parent's permission) moving into a placement with Foster Carers 1. Faith was clearly distressed at leaving her half-sister and there were several instances of her going missing from care.

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| Social workers responded to concerns about Faith by removing her from the family environment. Although the section 7 report had begun to question the assumptions about family dynamics and relationships, the impetus to deepen this understanding became lost with a change of social worker and the focus of work with Faith became unclear. When she was accommodated there had been no placement planning meeting, and this was the beginning of a pattern that continued throughout Faith's time in care whereby there was no clear plan for family contact that was understood by all parties involved. |

6.14 Whilst in this placement, in June 2010, Faith was admitted to the paediatric ward with medical problems. Her foster carer told the nurses for looked after children that Faith had gone to an aunt after school and the aunt was a "convicted paedophile". The nurses referred to Children's Social Care who decided not to hold a strategy meeting but to refer to the NSPCC to address Faith's emotional needs. The next day the nurse for looked after children again contacted Children's Social Care to express the concerns of the paediatrician, but at this stage still no further action was taken as it was the view of Children's Social Care that the medical problems were self-inflicted.

6.15 There were more episodes where Faith went missing from the foster carers and was admitted to hospital having taken an overdose. Social work records note that just prior to this she had made a partial disclosure regarding sexual abuse by a male known to the family when she was age 9 and 11 but she did not want to discuss further. She was assessed by CAMHS[7] as having "no mental health problems and low risk of completed suicide". The day after discharge she was again readmitted with an overdose, Foster Carers 1 could no longer cope, and Faith moved to a new placement with Foster Carers 2 (via a private fostering agency).

6.16 In August 2010, there was a review child protection conference and all three children's names were removed from a plan.

6.17 It seems that due to concerns about Faith's emotional wellbeing, a report was commissioned from a private psychiatrist. This review has been unable to establish unequivocally why the terms of reference for this assessment stated that no enquires should be made of Faith in respect of the issue of sexual abuse. It is the view of Children's Social Care that the most likely reason was that the concerns were about emotional wellbeing, there had been no disclosure from Faith of sexual abuse and questions regarding possible sexual abuse would be seen as leading or "fishing for information. This is discussed further in paragraph 9.4. The conclusions of the

[7] Child and Adolescent Mental Health Service

psychiatrist showed the characteristics of a child who had been subject to significant traumatic experiences. The report recommended in-depth therapeutic work.

6.18 A looked after child review noted that the plan was for Faith to remain with her current foster carer but to return home to her father “maybe after Christmas”.

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| During this period, it is not clear what *work* was being done with Faith and her family to underpin a plan for her to possibly return home to her father. Faith was undoubtedly torn about where she wished to live, was worried about her siblings and “voted with her feet” many times by returning to family members, but there does not seem to have been any plan of work which addressed the complexities of the family circumstances. |

6.19 In March 2011 a new social worker was allocated and in May 2011 Faith’s foster placement ended abruptly due to the foster carers separating and Faith moved in with Half Sibling 1. This prompted a move of school. There is note of an e-mail exchange between the social worker and the Independent Reviewing Officer[8]. The social worker informed the Independent Reviewing Officer that the family had effectively “de-accommodated” Faith as she had chosen to leave the foster placement and the family were happy for her to live with her half-sister. The Independent Reviewing Officer reminded the social worker that the plan should have been ended with a review. She also requested that the social worker looked at previous child protection records due to concerns regarding sexual abuse. (There is no evidence that the social worker did this). The email also refers to files not being available due to an office move and due to files not being available, the social worker could not tell the Independent Reviewing Officer why the psychiatrist had been instructed not to discuss sexual abuse.

6.20 There was some additional confusion as the social worker also suggested that the case would be managed under child in need but subsequent recording of visits to Faith at her half-sisters are referred to as “LAC visits” (i.e. visits to a child who is still in the care of the local authority).

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| At this stage of work with Faith there seems to have been a loss of focus by Children’s Social Care, exacerbated by a change in social worker and the new worker not having access to all the relevant information due to restructuring of teams within the department. |

6.21 In June 2011, Children’s Social Care records note that she was no longer a looked after child and from this point Faith began regular meetings with a practitioner from CAMHS. Faith spoke to the special educational need’s coordinator at school about her worries concerning her siblings who were living at home with her father. She described recently staying with her father and her father receiving death threats and being attacked and she was extremely scared and guilty about leaving her siblings. The school appropriately shared this information with Faith’s social worker and the

[8] Independent Reviewing Officers ensure the care plans for children in care are legally compliant and in the child's best interest.

school's Police community support officer. When followed up by the social worker, there were inconsistencies between Faith's and Father's version of events and no further action was taken.

6.22 There were further concerns at school regarding self-harm, possible sexual activity, verbal and physical aggression which resulted in a five-day exclusion from school. At a professionals meeting held at school (attended by the social worker), concerns were expressed that Faith's behaviour had escalated rather then settled since living with her sister and it was agreed that an application for a Special Educational Needs statement would be made.

6.23 In July 2011, Father presented at the social work office with Faith as the living arrangement with her half-sister had broken down. He agreed to keep her whilst the local authority looked for another placement, but no placement was found, and Faith remained with Father. Contact with her mother was to be supervised although there was no court order to back this up.

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| This sequence of events is an example of Faith feeling that she was not being listened to. She expressed concerns about the environment at home, but her Father's account was believed and then she was returned to his care when she needed accommodation. |

6.24 In September 2011, Faith who was still living with Father, moved back to the school she had been attending prior to her move to her half-sister. In-school counselling was arranged via CAMHS but she attended none of the six sessions.

6.25 From November 2011 through to January 2012, there was continued contact with the community CAMHS practitioner. Faith found that her mother was pregnant again and self-harm led to a hospital admission. The GP was informed but there is no record of any follow up. There was a CAMHS risk assessment on the ward with a plan for follow up by the CAMHS practitioner.

6.26 From February through to May 2012, Faith continued to see the CAMHS practitioner regularly and it is clear that her behaviour was difficult to manage at school. The CAMHS worker brought to the attention of the social worker the recommendation from the previous psychiatric assessment that Faith should receive therapeutic input and suggested that this was still relevant. There is mention within the records of Faith having supervised contact with her mother.

6.27 In July 2012 there was an updated core assessment. All of Faith's challenging behaviours are attributed to parental substance misuse and domestic abuse within the family during her early childhood. There is no mention of sexual abuse or assault as part of her experience. At this point Faith had had the same social worker and manager for four years.

6.28 In November 2012 Faith was accommodated again due to 'high levels of stress' in the family". She was reportedly violent towards her younger siblings. She was accommodated at a Local Authority home and from the start she gave the staff the

impression that she had a volatile relationship with her father and wanted to single handedly “save” her mother.

6.29 In December 2012, a residential worker called the Police concerned that Faith was being taken to a 50-year-old male’s home by another female four years older than her. Police informed Children’s Social Care. In Medway in 2012, professional knowledge about child sexual exploitation was in its infancy but at the very least this episode should have triggered a response that was more proactive in exploring the risks that Faith was being exposed to. It would have been most appropriate for this response to be led by her social worker. This did not happen.

6.30 There were concerns from the school due to cut marks on Faith’s arms and over the Christmas period she attended hospital complaining of pain and headache and had two black eyes and reported falling and hitting her head when drunk four days earlier. She was discharged to the care of GP.

6.31 In January 2013, Faith reported to a member of residential staff that she had been raped by her mum's friend as a nine-year-old and memories had been triggered as she had recently seen the man in the local area. She said this had led to her self-harming and that her mum knew but did nothing. This was reported to the Police and Faith told the Police that she was sexually assaulted but because her statements were conflicting, no further action could be taken.

6.32 In relation to the wider network, around this time Faith had three assessment sessions with CAMHS psychotherapist. There is also an admin entry in the GP records (she had possibly changed GPs as a result of moving into residential care) providing further detail of Faith’s medical history, but this was not complete and did not include allegations of rape.

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| This was the second specific allegation by Faith, and it is interesting that this was made soon after moving away from the family into residential care. The response by agencies is discussed more fully in Finding One. What is clear is that the GP service was not fully aware of the details of Faith’s history and could not take this into account in any contact they might have had with her. |

6.33 In February 2013, Faith was noted by the residential unit to be self-harming and worried about her mother’s health. She assaulted another female resident, was arrested and admitted the assault for which she received a reprimand.

6.34 At the March 2013 LAC review Faith was noted to have settled reasonably well but there was then a report of “aggressive and violent behaviour” at school and later in the month Faith lost her work experience placement.

6.35 There followed reports of altercations with residents in the home and from June – August 2013 there were more episodes of Faith being missing from the unit and on the majority of occasions she was with her mother.

6.36 In September 2013, Police received a call from a previous member of staff to the residential home expressing concerns regarding her and another female resident

being sexually exploited and specifically that Faith's mother was an alcoholic and would meet up with older males when Faith was with her. He was concerned these issues were not being addressed. A referral was submitted to Children's Social Care and there is no evidence of any response by Faith's social worker to this information.

6.37 Also, in September, Faith was a victim of an assault from a fellow male resident who was arrested and charged. Faith presented at the local hospital emergency department with chest/abdominal injury and was discharged with advice and reassurance. There was no documented record of contacting Children's Social Care.

6.38 In December 2013, due to changes in the CAMHS service the practitioner who had been seeing Faith regularly since approximately 2011 left the department. From Faith's perspective this felt like a very sudden departure.

6.39 In the first months of 2014, there were concerns about increasing self-harm, but no female therapist was available at CAMHS at that time[9]. Along with other residents Faith ingested bleach and it was decided to move her to an out of Borough therapeutic home for young people. Faith did not settle in the therapeutic placement and at the end of April left to live with Half Sister 2.

6.40 In June 2014, Faith and her half-sister were homeless and placed in a guest house. In July they were given temporary accommodation but were evicted two weeks later due to concerns about their behaviour. In August, Faith moved to a home for young people age 16+. She was reported missing twice within the first month and was also arrested for assault.

6.41 In September 2014, concerns about Faith increased with reports of attempted robbery, assault and increased contact with her mother including the possibility that she was being sexually exploited. (This was referred to in the records as possible involvement in "prostitution")[10]. At the end of September, a multi-agency strategy discussion was held, Faith had been missing for a week and there is a record that the social worker was considering secure accommodation.

6.42 In October 2014 Faith returned to the placement and refused to talk to the Police. She was allocated to a student social worker from the YOT team and the nurse for looked after children (who had a good relationship with Faith) planned a health assessment.

6.43 Faith pleaded guilty to a robbery charge and was bailed until November. Concerns increased regarding Faith's contact with her mother and the possibility that she was involved in "prostitution and drug running". These concerns were discussed at a professionals meeting and it was agreed that the accommodation provider would be requested to report Faith missing if she was absent from the premises without providing an address that could be checked by Police.

[9] A female therapist became available in April after Faith had moved out of Borough and the case was closed to CAMHS.
[10] In 2014 this was an outdated term to use.

6.44 In November 2014, records of the youth offending team and Children's Social Care note concerns that Faith was pre-occupied with her mother's needs. There was a report of a domestic violence incident between them indicating a volatile relationship. The Police requested a strategy meeting and agreed that the social worker should arrange a multi-agency meeting focused on keeping Faith safe. On 12th November Faith was cautioned for battery committed on 15th August 2014. Faith continued to be missing from placement returning with new boots and her eyebrows waxed – it was unclear where she had got the money from but there continued to be no formal assessment of risk relating to any form of exploitation.

6.45 In December 2014, Faith continued to go missing from the placement and was served with a 28-day notice to leave. At her review there is a note of concerns regarding sexual exploitation and her father is recorded as believing that she should be in secure accommodation.

6.46 In January 2015, Faith was reported missing 20 times. There are also records of violent behaviour within the accommodation with Faith being both perpetrator and victim. Faith moved to a residential children's home out of Borough.

6.47 In March and April 2015, Faith was reported missing three times and the residential home contacted the looked after children team, concerned that she was having unsupervised contact with her mother and father. There were also reports that she was using drugs and missing appointments with the youth offending team worker.

6.48 From August to September 2015 there were various attempts by the Youth Offending Service to engage with Faith to no avail and a final warning letter was sent. Finally, a planning meeting took place at the end of September.

6.49 Concerns increased about Faith's health and wellbeing and she was moved in October 2015 to local 16+ accommodation, followed two months later by a move to local semi-independent living in the local area and registered with the local GP surgery.

6.50 During subsequent visits by her worker from the youth offending team, Faith spoke openly about various incidents in her childhood which the worker recorded as "horrific".

6.51 It was at this point that the nurse for looked after children began a health history in preparation for Faith leaving care and uncovered the safeguarding concerns that led to this serious case review.

From 2013 onwards, the focus of work with Faith was mainly on containment. Her worker for the youth offending team did work hard to develop a relationship and understand the causes of her behaviour but by this time Faith could not trust those she viewed as authority figures. She did develop a reasonably positive relationship with the nurse for looked after children possibly due to her being seen as part of health provision rather than an authority figure.

It is during this period that the failure to recognise what had happened to Faith and

respond positively when she made allegations can be seen to have resulted in an approach which could not meet her overall needs. The worries that her relationship with her mother could be linked to Faith being sexually exploited were recognised but not adequately assessed or addressed.

## 7 FAITH'S EXPERIENCE AS A CHILD AND YOUNG PERSON

7.1 Much of the information for this section has been provided by Faith and we are extremely grateful that she has been willing to contribute to this review. Although it has been painful for her to talk about her life, she has said that she hopes her story will prevent other children and young people going through the same experiences.

7.2 Faith's early memories are of a home life where there was a high level of violence and numerous disputes with neighbours and others in the community. The disputes between neighbours involved the children and Faith remembers being tied to a lamppost, petrol being put through the letter box and a car set on fire. She remembers the Police being aware of what was happening, but nothing changed. She remembers social workers coming to the house, but they did not ever see her outside the home. She could not say anything about her life in front of her parents as they had told her to lie.

7.3 As well as information gained directly from Faith, a review of the records shows that there were occasions when at the time she told people what life was like for her or there were descriptions of her circumstances, these should have made professionals think more carefully about her circumstances.

7.4 The record of the child protection conference in March 2008 gives a good picture of Faith's life at that time. It documents a little girl who was bright and could be in the top group of school, but her emotional state was preventing this and she was having difficulty coping with the work. She was often late for school, not always very clean and appeared to have an ongoing infection and frequently asked to go to the toilet during class. Homework was not always completed, and she did not take books home with her as they were not returned.

7.5 Again, the child protection conference in December 2009 had information about a girl who was extremely distressed and torn between her parents. The conference heard that she had described witnessing severe domestic incidents between her mother and father, including her father holding a knife to her mother and punching one another. She had also described being hit by her father with a leather slipper in the past causing severe bruising to the back of her legs. She had said 'he's marked me loads of times'. She also said that her mother would drink from the moment she got up until she went to bed but was with a new partner and was getting better. She also said that she had no friends at school because whenever they would knock at her house her Dad would tell them to 'f**k off'. At age 11 Faith was able to articulate that her parents were as bad as each other and she did not know who she wanted to live with. At this point she told social workers that her mother and father had told her to lie to social workers so the case would be closed.

7.6 Faith's view is that by the time she was taken into care it was *too little too late* and *I am not sure I even know what family means.* She remembers being glad to be out of the home but unhappy in care. Her view now is *at least strangers were treating me like crap – it is different when it is your mum and dad.* In her first placement she felt she was treated differently to the carer's own child, did not feel part of the family and the foster carers had not been fully prepared for what to expect. She remembers feeling unhappy at her second carers and at this point took an overdose.

7.7 By the time that Faith was in residential care her distress was evident through self-harm and behaviour that became labelled as "challenging". By this time Faith feels that she was punished for her behaviour rather than anyone recognising how she was feeling. Faith valued her relationship with the CAMHS practitioner but at that time felt that she could not speak to her openly as she did not want the practitioner to dislike her and opening up might have made the practitioner view her differently -*I would have lost her as a friend.* It was upsetting for Faith to lose her contact with the CAMHS practitioner when the service restructured, and she was unhappy that another female therapist could not be found. She also felt that the LAC nurse was the other person who really cared - *It is about someone being real.*

7.8 Throughout her adolescence Faith desperately worried about her family, had a volatile relationship with her parents and felt torn between them. She feels that during her time in the first residential placement she felt there was something wrong with her, was out of control and *at that time I did not know what I was capable of doing.* She now feels that she should have been put into secure accommodation at that point. From the perspective of staff in the residential unit Faith's behaviour was "off the chart" but so was the behaviour of all the young people in the unit at that time.

7.9 Looking back, Faith feels very angry that more effort was not made to help Half-Sister 2 look after her. She desperately wanted to be with her family and felt let down by her social worker. After she and her half-sister were evicted, and she moved into another residential home she remembers her social worker saying she would "phone on Tuesday" to see what could be done but no call came. Her half-sister often says, "I am still waiting for that Tuesday."

7.10 This is a very important significant contribution to this review, reminding practitioners of the importance of always keeping children and families fully updated about decisions that are being made. Practice should be about "working with" rather than "doing to" children and their families.

7.11 Faith remains very vulnerable and although therapy has been offered at the time of writing she has not felt able to access this therapeutic help.

## 8 SUMMARY OF OPPORTUNITIES TO PROTECT FAITH

8.1 Although much of the practice outlined above will have changed, and the agency responses to this review will identify specifically where service improvements have been made, it is important to be clear where there were opportunities to do things

differently. The following aims to identify pivotal points where alternative practice decisions could have made a difference and should provide a baseline for agencies to measure how far current practice addresses the deficiencies in the past.

| Age of Faith | |
|---|---|
| Five – Seven | At the point that the locum GP referred to a paediatrician, there was a 19-month delay before an appointment was given and a lost opportunity to explore the risks outlined in the GPs referral. The gynaecologist examining Faith did not have information about the wider family and the GPs concerns about risk. |
| Nine | Faith's change in behaviour at school and allegation of being tied up by a neighbour should have been assessed more thoroughly by Children's Social Care. |
| Twelve | The misgivings of the social worker who did not support Father's application for a Residence Order, became diluted once the Residence Order was granted in respect of the younger siblings. One underlying cause was likely to have been a change of worker at this point. |
| Twelve | Children's Social Care did not follow expected procedures following (a) a referral from the paediatrician that Faith had contact with an aunt who was a "convicted paedophile" and (b) subsequent disclosure by Faith of sexual abuse by a male known to the family. |
| Twelve | There was a lost opportunity to explore the possibility that Faith had been sexually abused at the point a report was commissioned from a psychiatrist who was asked not to make enquiries about sexual abuse. |
| Thirteen | A newly allocated social worker did not take the advice of the Independent Reviewing Officer and review previous child protection records. This seems to have been within the context of a department undergoing a great deal of change with previous records not being easily available. |
| Fourteen | An updated core assessment did not include any information about previous concerns regarding sexual abuse or physical assault in her early years. |
| Fourteen | A second disclosure of sexual abuse could have been investigated and assessed more thoroughly by Police and Children's Social Care. The Police were not aware of a previous disclosure made when she was age twelve as this had not been passed to the Police by Children's Social Care. |
| Fifteen | Allegations that Faith may have been sexually exploited were not properly investigated by police or Children's Social Care. |
| Sixteen | Further allegations of sexual and criminal exploitation were not properly investigated. |

## 9 FINDINGS & RECOMMENDATIONS

**Finding One:**
**Over many years the signs and indicators that Faith had been sexually abused were not recognised and acted upon and her "voice" was not heard.**

9.1 Although this review has had the benefit of hindsight, there was information known to professionals at various points in Faith's life that should have resulted in recognition that she may have been/was being sexually abused. This was important in relation to protecting her when she still lived at home, understanding her behaviour and vulnerabilities as a young person and considering any risks to siblings remaining within the household. Once she left home it is clear that Faith worried about her siblings and this was partly why she would return home frequently when in care.

**Understanding behaviour, trauma and vulnerability**

9.2 This was a complex family situation with concerns about neglect, violence and alcohol and drug use; factors which are explored further in Finding 2. This complexity appears to have obscured a focus on potential sexual abuse, and as Faith grew up her behaviour was generally seen as the problem, rather than the manifestation of previous trauma and distress.

9.3 There were exceptions when trauma in her past was recognised and discussed, but this fell short of specifically identifying and naming sexual abuse. For example, the youth offending worker told the review that her focus was on working with a young person who had been traumatised and to prevent her being further criminalised.

9.4 The lack of in-depth consideration of the possibility of sexual abuse was particularly notable in the report by the psychiatrist in September 2010 which noted that she showed the characteristics of a child subject to significant traumatic experiences. This psychiatrist is a known expert in the field of sexual abuse and in the introduction to the report notes that it was his opinion that she may have been the victim of sexual abuse but in carrying out the assessment he had been asked that there should be *no direct enquiries of her in respect of the issue of sexual abuse*[11]. As explained in 6.17 above, a possible explanation for this directive was that no disclosure had been made, and questions about sexual abuse could be seen as a "fishing" exercise. If this was the reason, it confuses criminal standards of evidence gathering with a need to protect her from harm and understand all the interlocking factors in Faith's life that were affecting her wellbeing.

9.5 From age 14 onwards the main indications regarding sexual abuse related to Faith's behaviour and vulnerability to exploitation by others. There is some evidence of concerns about her mother's part in this, but Faith's loyalty to her mother and desire to look after her would have made this very hard to address.

[11] Report of independent child psychiatrist September 2010

9.6 School can be an environment where young people may feel able to talk about abuse. The school were aware that she was vulnerable and although her behaviour was at times hard to manage, they understood her disruptive behaviour as a way of avoiding facing up to things. They did not at the time speak about sexual abuse although they were aware this was possible. The secondary school had a copy of the psychiatrist report which noted that the psychiatrist had been asked not to make direct enquiries about sexual abuse and therefore assumed that it would be damaging to discuss this openly. They also assumed that Children's Social Care "knew what they were doing" and were relieved that CAMHS were involved as so many of their pupils had problems accessing a CAMHS service.

**Medical indicators of sexual abuse**

9.7 There were opportunities to focus on sexual abuse as a result of medical symptoms as a young child. At this stage, Faith remembers hoping that doctors would realise what was happening as she could not say anything directly about life at home as she had been told to keep quiet by her parents. She also remembers staring hard at professionals hoping that they would realise that something was amiss.

9.8 The earliest opportunity to identify medical symptoms that may have been indicative of sexual abuse was in March 2004 when Faith was aged six. The locum GP who saw her at this stage identified a combination of potential risk factors (social and medical) and specified these concerns in a referral letter to the community paediatrician. Although this should have been sent directly to the hospital paediatricians the Health Trust has been unable to explain why the letter was not passed to the correct department and it took a chasing letter from the same GP practice to prompt an appointment 19 months later. The paediatrician who saw Faith in clinic at this time was working as a neonatologist. The review has queried why a doctor specialising in newborn babies saw Faith but has been informed that this doctor was a suitably qualified paediatrician who had a specialist interest in neonatology.

9.9 The neonatologist correctly took advice from the designated doctor and checked with the safeguarding team in the hospital who, at that point, had no record of Faith. It was appropriate that the neonatologist referred to a gynaecologist, but the original letter from the GP was not included in the papers and the gynaecologist only saw a letter from the neonatologist saying there were "no psychosocial problems". In this context sexual abuse did not form part of the "differential diagnosis"[12].

9.10 When Faith was referred to the gynaecologist at age 10, the gynaecologist was not aware that she was subject of a child protection plan and having spoken to her parent wrote in the records "no worries about abuse". There was a further opportunity for the gynaecologist to consider Faith's symptoms within a social context when the education welfare officer wrote asking whether her symptoms could result in her

[12] This is the process of differentiating between two or more conditions which share similar signs or symptoms.

missing school. However, since there had been no other concerning factors this did not trigger any further queries by the gynaecologist.

9.11 The following month the gynaecologist's secretary received a request from the school nurse for copies of the letters in the file to "inform the child protection plan". This was dealt with as an administrative matter and the gynaecologist remained unaware of any concerns by other professionals about the risk to Faith. Today the process would be that any such request should be made via the hospital safeguarding team and the expectation would be that they would make direct contact with the consultant.

9.12 Gynaecologists are primarily focused on care of adult women, although some may have an interest in treating children and this episode highlights the importance of gynaecologists who see children having good safeguarding knowledge and access to the right information. Two issues have been identified through discussions with practitioners:

1. The advisability of pre-pubescent girls being seen jointly by a paediatrician with links into child safeguarding networks alongside a gynaecologist.
2. The possibility that some children may be seen by gynaecologists (for example in emergency clinics) who have not completed level 3 safeguarding training.

**Responding to disclosures**

9.13 Although there is an argument for using the term "allegation" rather than "disclosure", this report uses the term disclosure as, from Faith's perspective she *was* disclosing to professionals what had happened to her. The first direct disclosure of sexual abuse was when Faith was age 12.

9.14 Just prior to this she had been admitted to hospital with physical problems and the hospital became aware that she may have had contact with an aunt who was a known sex offender. The paediatrician asked Children's Social Care to investigate but the management decision was that since there had been no disclosure the problems could have been self-inflicted, and no further action was needed. Children's Social Care have not been able to give an explanation to the review as to the reason behind this decision, but it seems that again the lack of a "disclosure" seems to have been influential in the case.

9.15 Less than two weeks later Faith disclosed to her social worker that a male known to the family had forced her to have sex on two occasions when she was aged nine and 11. Just after this disclosure she was re-admitted to hospital having taken an overdose of tablets found at her foster carers. She was seen by a CAMHS worker and cleared for discharge.

9.16 Although there is reference to the need for a strategy discussion with the Police there is no evidence that this happened, and the lack of Police contact was queried by the named nurse at the hospital. The social worker assured them that the Police had been contacted but Faith would not speak to them and he/she would "sort it out in the

community". There is no record of any contact in the Police records and it seems that the social worker became diverted by Faith taking a second overdose and the need to find a new fostering placement as the carer did not feel they could cope with her any more. The social work focus was on managing the most current crisis rather than taking a look at the whole picture and working within expected child protection procedures and processes.

9.17 There is no evidence of any social work managerial oversight that picked up on the deficiencies in response and it is of concern that at this point no consideration was given to possible risks to other children who remained in the household.

9.18 The lack of police knowledge of this first disclosure is significant as, when Faith was fourteen, she made her second direct disclosure of sexual abuse in childhood and the police investigation did not take this into account. On this occasion she told a residential worker she had been raped by the older brother of her friend. The family concerned were also known to her mother. This disclosure was investigated and an ABE[13] interview undertaken but there was no further action due to the number of discrepancies in Faith's account. The quality of the police investigation has been subject to an internal investigation and areas for improvement identified, although it is unlikely that there would have been a realistic chance of prosecution even if these improvements had been made. What is more pertinent is that even though prosecution may have been unlikely based on the available evidence, the possibility that Faith had been subject to sexual abuse as a child should have been more firmly integrated into the assessments and plans for her going forward. Discrepancies in her account should have been understood in the context of a child living in a chaotic environment and the impact that this would have had on her at the time and her recall of events. A review of previous Children Social Care records would have found that the referral made by her school in 2007 and described in paragraph 6.5 above was around the time she alleged the rape took place.

9.19 It is important to reflect on Faith's comments about who she felt tried to help her. She valued the relationship with the nurse for looked after children and CAMHS practitioner although this type of CAMHS contact would not be available today. The CAMHS service has moved from a pastoral holistic treatment model to a clinically based mental health interventions model and it is impossible to judge whether this would have made a positive difference to Faith at that time and prompted her to talk openly about any experience of being sexually abused. What is known is that the ending of the relationship was abrupt as the worker left when the service was transferred to another provider and there were insufficient female therapists to allocate Faith a worker when she needed it.

[13] An Achieving Best Evidence (ABE) interview is an interview of a vulnerable victim or witness carried out under Ministry of Justice Guidance https://www.cps.gov.uk/sites/default/files/documents/legal_guidance/best_evidence_in_criminal_proceedings.pdf

9.20 The overriding impression was that the possibility Faith had been/was being sexually abused rumbled below the surface within the professional network. At times the concern became more acute, but any planned action soon became overridden by another apparently more pressing crisis. At this distance in time it is hard to fully understand what was driving professional responses although it is possible that there was a view that there would be insufficient evidence to bring anyone to court. This may have been the case but at no time did child care plans set out the possibility that Faith had been abused and what response was needed to meet her needs.

9.21 Discussion with professionals during this review has raised the question of how confident practitioners feel in discussing the possibility of sexual abuse either with children themselves or in forums such as child protection conferences. The review has heard that this may still be a current problem and that staff development activities need to focus on developing confidence in listening, responding and not being embarrassed.

9.22 Even though at the time there may have been reservations about what could be done in relation to relatively non-recent allegations of abuse it is hard to understand why there was not a more coherent approach to concerns that Faith was being sexually exploited, her mother may have been involved and that this was linked to drugs and possible criminal exploitation. The first national guidance on child sexual exploitation had been published in 2009, four years before there were significant concerns about Faith and this should have influenced the way professionals responded.

9.23 The sexual abuse pathway within Medway should now provide a framework for working more effectively with situations where there are concerns about sexual exploitation. Further consideration now needs to be given to the effectiveness of work where there is also a concern that criminal exploitation is also a feature of the young person's life.

9.24 More recently, Kent police have recognised the need to improve their response to children and developed an approach to their work in line with the national strategy for child centred policing. The Kent police child centred policing plan contains a section specifically on the voice of the child and in January 2019 the police reporting structure changed in order to make sure that the voice of the child is captured within records.

**Recommendation One**
Partner agencies in Medway should review their staff development activities in relation to child sexual abuse and sexual exploitation to ensure that all practitioners have the required knowledge, skills and confidence to recognise and respond to child sexual abuse within the family including hearing the "voice" and lived experience of the child.

**Recommendation Two**
Consideration should be given by Medway Hospital to pre-pubescent girls being jointly

seen by a gynaecologist and a paediatrician (or a relevant specialist children's practitioner). Best practice would be a joint paediatric/gynaecologist clinic for these patients.

**Recommendation Three**
All partner agencies should promote the use of the sexual abuse pathway in cases of sexual abuse and sexual exploitation, emphasising the use of the Sexual Assault Referral Centre (SARC), and make sure that the pathway is embedded into day to day practice.

**Recommendation Four**
All partner agencies should work together to consider the effectiveness of recognition and response in situations where criminal exploitation may feature in a young person's life.

**Finding Two**
**Assessments and plans were limited in their analysis of the history of both parents, the dynamics of relationships within the family and relevant health information.**

9.25 There is little evidence that assessments and plans explored the family history, dynamics of relationships and any discrepancies in accounts given to professionals. This meant that assessments lacked depth and did not fully analyse the experience of children in the family, any risks they may face and the needs of individual family members. Responses to the family including child protection plans therefore did not take account of the complexity of needs and work with the whole family to improve the lives of the children including Faith.

9.26 For example, information obtained for this review shows that Father had a significant criminal history including a two-year prison sentence for drug related offences after the birth of Faith. Some (but not all) aspects of this were known but were not given sufficient attention when considering the overall dynamics of the family and their interactions with the local community. In face to face conversations, Father minimised his criminal history, although at the time of his application for Residence Orders further information from Faith and her half-sister indicated that he had not been entirely honest. Father's response may have been understandable, but his account was not challenged and explored further in the context of the known neighbourhood disputes and reports of family violence.

9.27 The section 7 report at the time of Residence Order application did question Father's capacity to care for his three children and argued against an order being made. However, once the Order was agreed in respect of the two youngest children the focus moved away from his capacity to parent. A new social worker took over Faith's case and work with the family from this point seemed based on the premise that Faith's mother was the main problem. It is likely that the reality was more complicated than that. This social worker (and manager) worked with Faith for several years and there is little evidence that any alternative hypotheses were considered. Further assessments and plans would have benefited from an analysis

of a chronology which set out the history of both parents, their relationship and the experiences of all the children in the household. Such an analysis may have helped to understand the cause of any specific risks to the children and focus services more clearly on protecting Faith from harm and working with the family system.

9.28 Faith feels strongly that practitioners should have been more curious about the relationships within the family and to have asked questions about why her older half sibling wished to leave home and move in with her birth father at the age of 13.

9.29 A common thread from discussions with Faith and those who worked with her is her strong loyalty to all her family and her wish to help and protect her siblings and her mother. There is no indication that this was properly understood and addressed or that the system provided any structured help to Faith's mother, thus putting a burden of responsibility on Faith. Many of Faith's episodes missing from care were linked to her making contact with her mother. If more attempt had been made to work *with* Faith's mother, it is possible (but by no means certain) that her knowledge of the sexual abuse experienced by Faith would have come to light. The recent call for more focus on real partnership working with families and sophisticated services that address the needs of the whole family is of relevance here.[14]

9.30 Assessments were limited in their knowledge and use of health information. There is little evidence of social workers contacting health professionals for information and similarly not all health professionals would have been aware of concerns within Children's Social Care. The full extent of GP understanding at this time has not been possible to explore further as records from the time have not been available to the review. The review was informed that this is still an issue today with health visitors not being asked for information when a child and family assessment is taking place and nurses for looked after children not being invited to strategy meetings for children who are looked after by the local authority. There is also a current concern that integration of health information is more problematic because Named Nurse[15] and health safeguarding access to the social work database (Framework i) has been removed as a result of GDPR[16].

9.31 In respect of current systems Children's Social Care have informed the review that systems are set up to link all past involvement, information and concerns about a child. Agency checks are now described as more thorough with the introduction of a Multi-Agency Safeguarding Hub (MASH) and information sharing agreements being in place. Given the concerns expressed by health colleagues above, this is an area that needs further attention in order to understand the differing agency perspectives.

[14] Trowler, I (2018) Care Proceedings in England: The Case for Clear Blue Water. University of Sheffield and Crook Public Service Fellowships. Page 7.
[15] All providers of NHS funded health services should identify a dedicated named doctor and a named nurse for safeguarding children. Named practitioners have a key role in promoting good professional practice within their organisation and agency, providing advice and expertise for fellow practitioners, and ensuring safeguarding training is in place.
[16] General Data Protection Regulation

**Recommendation Five**
Partner agencies should work together to develop an agreed multi-agency whole family approach to work with complex families. This approach should include expectations regarding information sharing and understanding and working with the root causes of adult issues that are affecting parenting capacity.

**Finding Three**
**There was no clear plan to give Faith a permanent safe home and the legal framework was not used effectively. When she was accommodated, planning lacked focus, did not manage family contact and there were missed opportunities to explore the meaning of her behaviour, particularly at times of placement breakdown.**

9.32 There is an overwhelming sense that throughout Faith's time accommodated by the local authority, practitioners struggled to provide the professional and human response that was needed when working with an extremely troubled child.

9.33 It is questionable as to whether section 20 voluntary accommodation provided the structure and stability that Faith needed. Part of the problem (as identified in Finding Two) was that the risks within the family environment had not been properly analysed, adequate help had not been provided in a very complex family situation and the potential for long term change not addressed. Although accommodated, family dynamics continued to adversely affect Faith and she bounced between family members with her unrelenting focus being on trying to look after her mother with her father threatening to reject her when she and Mother had contact.

9.34 The independent reviewing officer during the time was concerned that section 20 was not appropriate and that the required consent from Mother had not been obtained. At that time there was no culture within the department of independent reviewing officers escalating any concerns and their focus became keeping the placement stable to prevent Faith going home.

9.35 The independent reviewing officer was also aware that the social worker was struggling to keep Faith on board, and it seems that in trying to keep Faith engaged there was a lack of structure to her contact with her parents. Contact was driven by Faith (and her father) rather than an analysis of what would be best for her wellbeing. Since voluntary accommodation meant that her parents could remove her from care at any time, the focus seems to have been on not "rocking the boat" and consequently no one looking after Faith had a clear framework for managing contact and absences from care.

9.36 There are three alternative possibilities here. One is that greater efforts should have been made to support Faith's half-sister to look after her- this is what Faith feels should have happened although the records would suggest that there were serious concerns about the potential risks. The second is that section 20 should have been underpinned by more structured planning, work with the whole family and greater

challenge to Faith's parents when they seemed to disrupt the placement or thirdly, a recognition that Faith was likely to have most stability via a legal order. The independent reviewing officer did ask the social worker on more than one occasion whether legal advice had been sought and was told that it had but the threshold was not met. There is no record of any such advice being sought from the legal team.

9.37 What is clear is that there is a notable absence of the effective use of disruption meetings within the local authority at the point of placement breakdown. This would have provided an opportunity to reflect on the underlying causes of the breakdown and plan next steps, including whether a legal planning meeting should be convened and whether any kind of court order was needed to protect her, including the use of secure accommodation.

9.38 Although Faith feels that secure accommodation[17] should have been considered when she was in the first residential placement, it seems that people who knew her at that time did not feel that she was at the most serious end of the spectrum in terms of behaviour and would not have met the legal threshold. Later, when there were concerns about her involvement in the supply of drugs and risk of sexual exploitation the need for a legal order could have been considered but there is no evidence that any kind of structured thinking or planning took place to determine whether or not this was the right route for her.

9.39 There are strong views about the use of secure accommodation. Martin Narey in his review of residential care[18] commented on this and the wide variation in the use of secure accommodation between local authorities. He noted:

*Some senior social work managers pride themselves on never, or very rarely, resorting to secure use because they consider that to do so, is somehow morally wrong, and that a child is being essentially imprisoned without due process. I believe that means that the benefits of a secure placement are sometimes overlooked by commissioners*. (page 30).

9.40 Another factor is the knowledge that there is a shortage of secure places with a court in 2018 declining to make an order after no suitable placement could be found[19]. The Department for Education's response to the Narey review including funding to increase capacity may prevent concerns about availability influencing assessments in the future.

9.41 If a secure accommodation order had been granted this would have been for up to three months in the first instance and then for periods of up to six months on

[17] Under section 25 Children Act 1989 a secure accommodation order can be made where:
a) A young person has a history of running away, is likely to run away from any other kind of accommodation and if he runs away is likely to suffer significant harm; or
b) If the young person is not kept in secure accommodation he is likely to injure himself or other people.

[18] Residential Care in England Report of Sir Martin Narey's independent review of children's residential care, July 2016

[19] http://www.communitycare.co.uk/2018/10/16/judge-bemoans-distorted-market-young-peoples-secure-accommodation/

subsequent application to the court. From Faith's perspective this would have given her the space and stability to engage in therapeutic work.

9.42 It is not clear whether any of the above concerns affected thinking in Medway. The impression is that the most likely explanation is that decisions were affected by a more fundamental lack of effective assessment and plans that were not always informed by all relevant information. For example, Faith's allegation of rape made in January 2012 was not included in the social worker's report for the Looked After Child review. It is important to note that the review has been told that the planning process today would be different than it was when Faith was accommodated, and the Safeguarding Children Board will need to be assured that this is the case.

9.43 Understanding the causes of placement breakdown should have included a focus on the impact of early experiences on Faith's behaviour and whether her therapeutic needs were being adequately met. Agencies were possibly lulled into a false sense of security because a CAMHS worker was involved and the working context was not one where a multi-agency approach to providing child mental health services was everyday practice. There is evidence that Faith's school tried to provide support but there was no planning across services that could have integrated the work of CAMHS, the school and social work services.

9.44 Children's Social Care have informed the review that the local authorities Legal Gateway reviewing system now reviews and provides management overview and planning in all cases where a child is accommodated under Section 20. All such children have specific plans where timescales are agreed, legal advice is sought and pre proceedings planning starts. Had this been in place for Faith, improved planning may have provided an opportunity to focus on her need for stability and clarity in expected contact with her family.

**Recommendation Six**
Medway Safeguarding Children Board should seek evidence from Children's Services that legal planning is used at an early enough stage and that this provides the framework for thorough assessments and ongoing work with the child and their family.

**Recommendation Seven**
Medway Safeguarding Children Board should seek evidence from Children's Services that the cause of placement breakdown is analysed via disruption meetings and that findings are incorporated into ongoing planning for the child.

**Recommendation Eight**
Partner agencies should establish a multi-agency approach to the provision of therapeutic services to children and young people and that this approach should clarify roles and responsibilities and at a minimum involves schools, health and social work services.

**Recommendation Nine**
NHS England should review the system for accessing both electronic paper and archived primary care records in order to ensure that it is fit for purpose in assisting GPs in their current practice and also any required statutory reviews.

## 10 SUMMARY OF RECOMMENDATIONS

### Recommendation One

Partner agencies in Medway should review their staff development activities in relation to child sexual abuse and sexual exploitation to ensure that all practitioners have the required knowledge and skills and confidence to recognise and respond to child sexual abuse within the family including hearing the “voice” and lived experience of the child.

### Recommendation Two

Consideration should be given by Medway Hospital to pre-pubescent girls being jointly seen by a gynaecologist and a paediatrician (or a relevant specialist children’s practitioner). Best practice would be a joint paediatric/gynaecologist clinic for these patients.

### Recommendation Three

All partner agencies should promote the use of the sexual abuse pathway in cases of sexual abuse and sexual exploitation, emphasising the use of the Sexual Assault Referral Centre (SARC), and make sure that the pathway is embedded into day to day practice.

### Recommendation Four

All partner agencies should work together to consider the effectiveness of recognition and response in situations where criminal exploitation may feature in a young persons life.

### Recommendation Five

Partner agencies should work together to develop a multi-agency whole family approach to work with complex families. This approach should include expectations regarding information sharing and understanding and working with the root causes of adult issues that are affecting parenting capacity.

### Recommendation Six

Medway Safeguarding Children Board should seek assurance from Children’s Services that legal planning is used at an early enough stage and that this provides the framework for ongoing work with the child and their family.

### Recommendation Seven

Medway Safeguarding Children Board should seek evidence from Children’s Services that the cause of placement breakdown is analysed via disruption meetings and that findings are incorporated into ongoing planning for the child.

### Recommendation Eight

Partner agencies should establish a multi-agency approach to the provision of therapeutic services to children and young people and that this approach should clarify roles and responsibilities and at a minimum involves schools, health and social work services.

### Recommendation Nine

NHS England should review the system for accessing both electronic, paper and archived primary care records in order to ensure that it is fit for purpose in assisting GPs in their current practice and also any required statutory reviews.

## 11 APPENDIX ONE: DETAILS OF LEAD REVIEWER AND PANEL MEMBERSHIP

11.1 Jane Wonnacott was appointed as an independent lead reviewer by Medway Safeguarding Children Board to carry out the review and write this report. Jane is a qualified social worker with over twenty years' experience of conducting Serious Case Reviews and is the author of over one hundred reports.

11.2 A panel was made up of senior professionals and was appointed to work with the lead reviewer. Members of the panel were:

- Detective Superintendent (Chair until January 2019) - Kent Police
- Named Nurse for Safeguarding - Medway Community Healthcare
- Head of Safeguarding - Medway NHS Foundation Trust
- Area Manager, Kent - NELFT
- Designated Safeguarding Nurse for Children and Families - NHS Medway Clinical Commissioning Group
- Detective Chief Inspector (Chair from January 2019) - Kent Police
- Head of Safeguarding and Quality Assurance – Medway Council
- Principal Social Worker, Children's Services – Medway Council
- Virtual Head Teacher, Children & Adults services, Medway Council
- Learning and Development Officer, Child Death Review Co-Ordinator - Medway Safeguarding Children Board
- Business Manager - Medway Safeguarding Children Board
- Project Support Officer – Medway Safeguarding Children Board

## 12 APPENDIX TWO: REVIEW QUESTIONS

1. Why were the early signs of child sexual abuse not recognised and acted upon across the partnership and are there lessons for practice today?

2. What were the barriers (individual and cultural) that stopped professionals from hearing the voice of the child/young person and acting to protect her when allegations had been made and/or there was evidence of abuse?

3. What do practitioners understand their powers and responsibilities are in relation to information sharing, how effective was communication and partnership working across the partnership, and how did this impact on the safety and wellbeing of the child/young person?

4. How far were the child/young person's overall health needs met, how effective was communication across the health community?

5. Were there any barriers that prevented practitioners from following up and challenging responses to referrals?

6. What does this case tell us about how effectively professionals engage with young people whose behaviour is described as “challenging and work with them to understand the meaning of their behaviour?

7. What were the barriers that prevented the child protection and legal processes from safeguarding the child, promoting her wellbeing and achieving permanence?

8. What is happening now across the partnership to improve practice in similar situations and are there further improvements that need to be made?

## 13 APPENDIX THREE: DOCUMENTS SUBMITTED TO THE REVIEW

- Children’s Social Care assessments
- Child Protection Conference Minutes
- Psychiatric assessment
- List of schools attended
- CSA pathway
- Section 7 Report from Children’s Services
- Serious Incident Report
- Kent Police – Investigation Review